HOUSING RETENTION

A Joint Effort Between Resident Services and Property Management

HISTORY OF SKID ROW HOUSING TRUST

Harm Reduction

Housing First

Supportive Housing Meetings

SUPPORTIVE HOUSING TEAM MEETING

IMPORTANT NOTES:

- PLEASE MAKE SURE THAT THE RENT AMOUNT AND NUMBER OF MONTHS BEHIND ARE BOTH WRITTEN IN THE AGENDA AND MINUTES.
- MAKE SURE RENT AMOUNTS ARE ACCURATELY ADDED UP.
- MAKE SURE THAT BOTH THE NAME AND UNIT NUMBER ARE LISTED.
- MEETING SHOULD TAKE NO LONGER THAN ONE HOUR.
- PROPERTY MANAGER TYPES THIS AGENDA UP, EMAILS TO REST OF TEAM BEFORE THE SUPPORTIVE HOUSING MEETING. EVERYONE SHOULD BRING THEIR OWN PRINTOUT TO THE MEETING.
- MINUTE-TAKING SHOULD ROTATE; MINUTE-TAKER DISTRIBUTES MINUTES BEFORE NEXT MEETING, EVERYONE SHOULD BRING THEIR OWN PRINTOUT TO THE MEETING.

DATE:

ATTENDEES:

ABSENT:

BUILDING/S:

1. **REVIEW OF PREVIOUS MEETING MINUTES**
2. **GRANT PROJECT REPORTS** – Housing Transition Specialist/s report, other grant reports *(If applicable)*
3. **RENT CONCERNS** (Past due and/or current month late)/**TENANTS ON RENT CONTRACTS/3-DAY NOTICES**
4. **EVICTIONS/ABANDONMENTS/COVENANTS/OTHER LEGAL ISSUES**
5. **TENANT CONCERNS** (including tenants on behavioral contract
6. **INCIDENT REPORTS/INFRACTIONS**
7. **ENTERING/EXITING TENANTS-none**
8. **HOSPITALIZED/INCARCERATED/MISSING TENANTS**
9. **VACANCIES**
10. **HOUSING RETENTION COMMITTEE REFERRALS**
11. **REASONABLE ACCOMMODATION**
12. **PEST CONTROL REPORT**
13. **FACILITIES ISSUES**
14. **ANNOUNCEMENTS:**

SKID ROW HOUSING TRUST

INITIAL NEEDS ASSESSMENT

This form is only for NEW move-ins and should be filled out within 30 days of move in

Move-In Date: **Assessment date:**

Resident Name:

Building/Unit:

Dimension	1	2	3	4	Level
Medical Care * Medical Status; Need for CM Intervention; Other Medical	In Care Reports an established medical home where resident sees provider on a regular basis.	Occasional Reports receiving care at one or more providers on an occasional non-emergent basis.	Frequent Does not have an established care provider and seeks out medical care less than three times a year.	Not In Care Reports no medical home or care provider and seeks out care via the Emergency Room.	
	ER visits in last 12 mo's = _____	ER visits in last 12 mo's = _____	ER visits in last 12 mo's = _____	ER visits in last 12 mo's = _____	
Mental Health * History, Risk, and/or Treatment Status	No History Denies history of mental illness or violence; no family history	Treatment History of illness but connected to treatment and/or medication	Treatment Inconsistent History of illness; connected with treatment and/or meds but reports inconsistent w/ recommendations	Not In Care / Untreated History of illness; active problems and in crisis; current psychiatric illness(es) are untreated	
Substance Abuse * History, Risk, and/or Treatment Status	No History No reported history of abuse at this time	Treatment History of abuse but connected to treatment; following treatment plan	Treatment- Current Relapse or History of Relapse History of abuse; needs high level of emotional support; connected to treatment but may have compliance issues; experiencing stress	Not In Care History of abuse; active problems; illness is untreated	
Support System Informal helping network, Reliability	Reliable Has reliable friends/family to provide ongoing support and/or other stable support	Questionable Often has support, but not always reliable	Crisis Only Some support in a crisis only	None No reliable support when needed	
Living Situation * Environment, Payments, Options	Transitioned From / Completed Long-Term or Residential Program	Transitioned From Short-Term Supportive Housing	Transitioned From Shelter, Jail, or Other Non-Supportive Housing	Transitioned Directly From Street and/or Meets Chronically Homeless Criteria	
Financial Resources Income/Savings, Benefits,	Stable Stable income/benefits adequate to meet needs: Employment, SSI/SSDI, VA, Retirement or any	Adequate Adequate income to meet needs: SSI, Retirement, Unemployment Insurance, employment, other sources	Inadequate Inadequate current resources; has not applied for benefits:	None No current resources:	
			GR: __ Yes ___ No	Food Stamps: __ Yes ___No	
Legal Affairs History of incarceration, outstanding tickets	None No history of incarceration; or parole/probation completed/discharged	Needs Help On parole/probation but compliant with all terms; seeking assistance with legal aid/public counsel/homeless court for	Some Assistance Requires help with meeting terms of parole/probation; inconsistent follow up with legal assistance	Full Assistance In danger of reoffending, non-compliant with terms of legal status; active warrants, no interest or follow up with advocacy	
Practical Assistance * Nutrition, Clothing, Hygiene, Mobility	Independent Able to independently provide for own needs and perform all activities of daily living (ADLs)	Some Assistance Can provide for some ADLs and arrange for the rest	Limited Limited capacity for arranging ADLs on a regular basis; may benefit from IHSS	Unable Extreme difficulty managing ADLs, requires assistance to arrange for food, clothing, and other ADLs, Resistant to IHSS	
Self-Sustaining Activities (SSA's)	Regular Regular involvement in spiritual, leisure, or other SSAs	Needs Needs education/exposure to SSAs	Not Engaged Does not independently seek SSAs involvement	Isolated Isolated from suitable SSAs	
Dental Significance of Dental Needs	None No dental needs beyond regular check-ups; has pay source	Minor Minor dental needs; may need assistance from 3rd party payer	Moderate Significant dental needs affecting other health; needs pay source	Major Major dental needs / pay source denied; noncompliant in correcting issues	
				Total	

*** = A significant finding (score of 3 or 4) in any of these categories may warrant the need for Comprehensive Case Management services.**

Significant Findings

Interpreter Needed? ☐ Yes ☑ No If so, language:

Scoring:

10 - 15: Limited Cases reviewed as needed, but at least every 90 days. Resident contact must occur at least once per month.	**16 - 30: Supportive** Cases reviewed at least every 60 days, CM Meetings at least twice per month.	**31+: Comprehensive** Cases reviewed at least once per month, CM Meetings weekly or more, if necessary.

Initial Level of Care Assessment:

Refer to: ☐ Limited ☐ Supportive ☐ Comprehensive

Date: _____ **RSC Name:** _____

RSC Signature: _____

PM Name: _____

PM Signature: _____

JOINT MEETINGS

JOINT TRAININGS

HOUSING RETENTION COMMITTEE

HOUSING RETENTION REFERRAL FORM

Tenant's Reference Number *(Admin Only)*: _____ **Date**: _____

Tenant's Move In date: _____ **SPC** -or- **Section 8** -or- **Market Rate** *(circle one)*

Number of infractions: _____ ☐ Rent ☐ Unit Condition ☐ Compliance

☐ Other: _____

Interventions with Resident:

- ☐ Meeting with Staff (RSC/PM)
- ☐ Contract
  - ☐ Compliance
  - ☐ Rent
- ☐ Outside Agency Referral
  - ☐ Money Management _____
  - ☐ Legal Aid _____
  - ☐ Treatment Program_____
  - ☐ Other _____
- ☐ Reason for Referral *(Please explain. Attach additional sheets if necessary)*

Document Checklist:

- ☐ Recent Infractions
- ☐ Contracts
- ☐ ADL
- ☐ Needs Assessment
- ☐ Other Pertinent Documentation

_____

_____

_____

_____

FOR COMMITTEE USE ONLY

Committee Recommendations *(Attach additional sheets if necessary)*:

Date: _____

RESIDENT SERVICES PARTICIPATION IN EVICTIONS

PMC REFERRALS TO RESIDENT SERVICES

SRHT PROPERTY MANAGEMENT COMPANY

an affiliate of Skid Row Housing Trust
1317 E. 7th Street
Los Angeles, CA 90021
213.683.0522 Tel
213.683.0781 Fax
www.skidrow.org

Date: 04/25/14

Resident Name Unit:

This is a Written Violation Notice documenting that you have violated your Lease Agreement, specifically:

Lease Agreement section:

House Rule(s):

Visitor Policy:

Other:

A copy of this letter will be placed in your resident file.

We strive to maintain a healthy and safe environment for all of our tenants and to work cooperatively with our tenants in achieving this goal. Multiple or serious infractions may lead to termination of tenancy.

You are welcome and encourage you to discuss this matter with your Case Manager. Management is also available to meet with you during posted drop in hours.

Thank you for your help in making this a great place to live.

Name/Signature Title Mgr. Date

Referral to RSC date

PEST CONTROL

RESIDENT SERVICES LOG SHEET

BUILDING ROUNDS WITH PROPERTY MANAGEMENT AND EXTERMINATOR

Building: _____

Date	Unit	Resident Name	Concerns *(e.g. cluttered, refused treatment, etc.)*	Action Taken	Initial